5. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

6. The Eval fields should be codes based on how the information was obtained, even if the related fields (Tumor Size, CS Extension) are unknown. In other words, just because the tumor size is coded 999, the Eval field does not have to be coded 9.

CS Tumor Size/Ext Eval Standard Table

***Note**: Not all schemas use the Standard Table. Be sure to check the site-specific schemas before coding the field.*
***Note:** This table is also available in the Quick Reference, Standard Tables Section.*

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. ***Does not meet criteria for AJCC pathologic staging.***	c*
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation **OR** surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen ***Meets criteria for AJCC pathologic staging.***	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on clinical evidence	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on pathologic evidence	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record ***For sites with no TNM schema:*** not applicable	c

* For some primary sites, code 1 may be a pathologic staging bases, as determined by the site-specific chapter in the *AJCC Cancer Staging Manual, sixth edition.*